

FILED FEB 14 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **241**  
Registrar's No. **119**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000**

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Joseph</b>		c. CITY OR TOWN <b>St. Joseph</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <b>50 yrs</b>		e. STREET ADDRESS (If rural, give location) <b>2305 Mitchell Ave.</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Missouri Methodist Hospital</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>Frank</b> b. (Middle) <b>Emerson</b> c. (Last) <b>Hutton</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>January 31, 1955</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>September 4, 1890</b>	9. AGE (In years last birthday) <b>64</b>	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Special Delivery</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Postal Service</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Lathrop, Missouri</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					

13a. FATHER'S NAME <b>James O. Hutton</b>		13b. MOTHER'S MAIDEN NAME <b>Frances Lanham</b>		14. NAME OF HUSBAND OR WIFE <b>Abby F. Hutton</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>500-07-9611</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. Abby F. Hutton St. Joseph, Mo.</b>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Thrombosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>392 X</b>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **Jan 26, 1955**, to **Jan 31, 1955**, that I last saw the deceased alive on **Jan 31, 1955**, and that death occurred at **1:10 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>M. Allison M.D.</b>		23b. ADDRESS <b>Paris, St. Joseph, Mo</b>		23c. DATE SIGNED <b>2/3/55</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>Feb. 3, 1955</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>	
		24d. LOCATION (City, town, or county) (State) <b>St. Joseph, Missouri</b>			

DATE REC'D BY LOCAL REG. <b>Feb 9, 1955</b>		REGISTRAR'S SIGNATURE <b>Kathleen M. Allison</b>		485-5252 FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Minorhoffer-Flanagan Co. St. Joseph, Mo</b>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

SEP. 20 1958

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \*\*\*\*, Student Embalmer No. \*\*\*\* working under my personal supervision..

Student \*\*\* \*\*\*\* Signature of Student Embalmer

Signed *Albert E. Fanning*

Licensed Embalmer No...3258

P. O. Address ....St. Joseph

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license). If embalmed by a STUDENT, he also shall sign in his OWN handwriting. If this body is not embalmed, fact should be so stated above.